



EMS TRAINING PROGRAMS APPLICATION

THIS SECTION IS FOR DEPARTMENT USE ONLY

DPH/Regional Approval Number:	Date Received from Revision(s):
Date Received-Regional EMS Office:	Date Approved by Regional EMS Office:
Date Returned for Revision(s):	Date Facility Notified by EMS Regional Office:

COURSE APPLICATION FOR PROGRAM
(CHECK ONLY ONE)

Emergency Medical Responder	<input type="checkbox"/>	Advanced EMT	<input type="checkbox"/>
EMT	<input type="checkbox"/>	Paramedic	<input type="checkbox"/>

GENERAL INFORMATION

Sponsoring Agency			
Mailing Address			
Course Location		Program Site Code	
Course Coordinator		Instructor Number	
Mailing Address			
Telephone		Business Hours	
Email Address			

COURSE INFORMATION

Course Starting Date		Course Ending Date	
Projected Number of Students		Times Class Held	
Classes To Meet (days of week)			

Medical Director

Name			
Mailing Address			
Phone		E-mail Address	

My signature affirms that the information contained herein is certified as true and correct to the best of my knowledge. Any changes to the application (schedule, instructors, contracts, etc.) after it is approved **MUST BE** submitted in writing and approved by the Regional EMS Program Director prior to the effective date(s) of the change. *(ALL SIGNATURES MUST BE ORIGINAL)*

Printed Name of Course Coordinator	
Signature and Date of Course Coordinator	